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HOUSE BILL 480

By Clemmons

AN ACT to amend Tennessee Code Annotated, Title 56 and Title 71, relative to coverage for mental health treatment.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) Every managed care organization that participates in the TennCare program shall submit an annual report to the bureau of TennCare on or before March 1 of each year that contains the following information for enrollees in the TennCare program:

(1) The frequency with which the managed care organization required prior authorization for all prescribed procedures, services, or medications for mental health and alcoholism or drug dependence benefits during the previous calendar year and the frequency with which the managed care organization required prior authorization for all prescribed procedures, services, or medications for medical and surgical benefits during the previous calendar year. Managed care organizations must submit this information separately for inpatient benefits, outpatient benefits, emergency care benefits, and prescription drug benefits. Frequency shall be expressed as a percentage, with total prescribed procedures, services, or medications within each classification of benefits as the denominator and the overall number of times prior authorization was required for any prescribed procedures, services, or medications within each corresponding classification of benefits as the numerator;

(2) A description of the process used to develop or select the medical necessity criteria for mental health and alcoholism or drug dependence benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(3) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and alcoholism or drug dependence benefits and medical and surgical benefits. There may be no separate NQTLs that apply to mental health and alcohol or drug dependence benefits but do not apply to medical and surgical benefits within any classification of benefits;

(4) The results of an analysis that demonstrates that for the medical necessity criteria described in subdivision (a)(2) and for each NQTL identified in subdivision (a)(3), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health and alcoholism or drug dependence benefits are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

(C) Identify and describe methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL as written for mental health and alcoholism or drug dependence benefits are comparable to and no more

stringent than the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(D) Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL in operation for mental health and alcoholism or drug dependence benefits are comparable to and no more stringent than the processes or strategies used to apply each NQTL in operation for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the managed care organization demonstrating that the results of the analyses required by this subdivision (a)(4) indicate that the insurer or entity is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343) and its implementing regulations, which include 42 CFR 438.900, 42 CFR 438.905, 42 CFR 438.910, 42 CFR 438.915, 42 CFR 438.920, and 42 CFR 438.930 and any other relevant current or future rules;

(5) The rates of and reasons for denial of claims for inpatient, outpatient, prescription drugs, and emergency mental health and alcoholism or drug dependence services during the previous calendar year compared to the rates of, and reasons for, denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year; and

(6) A certification signed by the managed care organization's chief executive officer and chief medical officer that affirms that the managed care organization has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with this section and the Paul

Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343).

(b) The bureau of TennCare shall monitor managed care organization claims denials for mental health and alcoholism or drug dependence benefits on the grounds of medical necessity within each classification of benefits among inpatient benefits, outpatient benefits, prescription drugs, and emergency care. The bureau of TennCare shall study and compare denial rates among each managed care organization and shall request additional data if significant discrepancies in denial rates are found.

SECTION 2. This act shall take effect July 1, 2017, the public welfare requiring it.